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TESTIMONY OF BILL BERENSON
PRESIDENT, AETNA, ILLINOIS MARKET

PROVIDED TO THE

ILLINOIS HEALTH REFORM IMPLEMENTATION COUNCIL

Aetna looks forward to working with the Illinois Health Reform Implementation Council on the Patient Protection Affordable Care Act (PPACA). While we work towards implementation of the Act at the federal and State levels and are committed to implementing the provisions of PPACA, at your request I have prepared our thoughts and recommendations with respect to our general comments on certain insurance reforms. My comments today will address three issues: (1) insurance exchange; (2) the medical loss ratio (MLR) requirement; (3) and cost containment.

EXCHANGES

First, PPACA requires states to establish an Exchange for the individual and small group markets by 2014. Aetna believes that an effective Exchange marketplace is critical to the success of federal reform and our recommendations are that it should:

(1) Promote consumer choice through a competitive and innovative insurance market. This includes:

- *Permitting broad insurer participation in the Exchange* if insurers meet state and federal requirements, to allow maximum choice for consumers.
- *Allowing insurers to offer additional buy-up benefits through the Exchange,* creating more customization and product choice to meet consumer needs.
- *Giving insurers the flexibility to offer various combinations of benefit tiers* to ensure that insurers can remain in the market even if they are unable to provide all five levels of coverage.

(2) Minimize market disruption through thoughtful, incremental implementation of new federal reforms, such as:

- *Limiting Exchange enrollment to individuals and groups with fewer than 50 employees* to expand access to those who need it most and minimize the likelihood that employers with healthier groups will self-fund.

- Individuals and employees of small employers (under 50) are most in need of additional access to insurance.
- Nationwide, 41% of small employers (under 50) offer coverage as compared to 96.2% of employers with 50 or more employees (Kff.org 2009).

- *Studying the impact of the new federal insurance regulations before requiring more restrictive state mandates* (e.g., medical loss ratio, additional benefit mandates) to minimize market disruption for consumers and ensure that premiums remain affordable.

(3) Establish an efficient regulatory environment that does not add unnecessary administrative burden and expense by:

- *Leaving regulation with insurance commissioners and not setting up Exchange regulatory frameworks* which could threaten plan solvency and create other problems for consumers.
  - Insurers should continue to set actuarially justified premiums rather than requiring plans to either negotiate or meet politically established rates.
- *Having industry representation on the Exchange Board* to ensure that there is insurance and actuarial experience contributing to the ongoing development of state Exchanges.
- *Continuing to allow insurers to bill and collect premiums* for products sold in the Exchange, rather than creating unnecessary expense by turning the function over to the Exchange.
  - The ACA prohibits wasteful use of funds by Exchanges [Sec. 1511(d)(5)(B)].

(4) Reduce rate shock for consumers by enforcing the individual mandate to ensure that the young and healthy are just as likely to purchase coverage as older or sicker individuals.

- The young and healthy may not purchase coverage because the 3:1 age bands will make their coverage more expensive, and the current statute's penalty of $95 in the initial year of coverage is not meaningful.

State enforcement mechanisms could include:

- *Allowing the Exchange to auto-enroll individuals* to facilitate higher participation levels.
  - Employers using auto enrollment for 401K plans resulted in 81%-95% participation of workers (largely young workers) as compared to 26%-60% when workers had to opt in (GAO, October 2009).
- *Creating additional enforcement mechanisms through existing state programs* such as the state tax system, vehicle registration or college enrollment.
- *Establishing an open enrollment period* to limit the potential for adverse selection.
  - According to Harvard Pilgrim's former CEO Charlie Baker, between April of 2008 and March of 2009, about 40% of people who bought individual insurance from Harvard Pilgrim stayed covered for less than five months, incurring an average of about $2,400 per person in monthly medical expenses.
  - In 2009, 936 people enrolled with Blue Cross and Blue Shield of Massachusetts for three months or less; the typical monthly premium for these short-term members was $400, but their average claims exceeded $2,200 per month (*The Globe*).

Overall, we believe that an effective exchange marketplace is critical to the success of federal reform and our recommendations are that there must be parallel systems whereby an exchange is available for certain coverages and a parallel system continues to exist outside of the exchange. In Massachusetts most individuals and small businesses finding access to and enrolling in coverage are doing so outside of the exchange. According to the latest statistics from the Massachusetts Health Connector, 3.5% of the total insured population in Massachusetts are enrolled through the exchange. The reason the exchange is important is that 85% of individuals enrolling through the mechanism are eligible for subsidies. Thus, there is a place for the private market to continue to function outside of the exchange.

MEDICAL LOSS RATIO

As one of the nation's oldest and largest providers of health care benefits, we understand the critical importance of thoughtful development of minimum loss ratio (MLR) definitions and standards under PPACA. These definitions and standards will determine the manner and extent to which health plans invest in activities to improve care quality and safety, reduce fraud, support members with chronic illnesses or complex health conditions, and maintain networks that offer both broad provider choice and affordability. The MLR definitions also will determine the willingness of health plans to enter new markets and/or remain in existing markets, particularly those markets in which the carrier has a relatively small market share. Meaningful consumer choice in the individual and small group markets will depend on the ability of plans to serve members effectively and to compete fairly without undue risk to solvency. To this end, to avoid these types of unintended consequences we recommend that Illinois consider two issues.

First, the law provides that there can be an adjustment to the MLR threshold for a state by waiver and/or if the Secretary determines that the application of the requirement could destabilize the market in that state. To this end, we urge Illinois to consider a waiver for certain markets for the MLR in 2011 until a final definition of MLR can be evaluated. Any waiver must be considered for all companies rather than on a company by company basis on the basis so as not to penalize or give advantage to some companies rather than others. Discussions have been underway at the NAIC regarding the fragile nature of the individual and small group markets and concern that the draft definitions may fail to account for the wide spectrum of insurer activities that contribute to better health outcomes and care delivery efficiency. We are concerned that there have been early warning signs from certain states asking or looking at asking for a waiver because of concerns about companies exiting the marketplace. Adoption of a narrow and static definition will adversely impact spending on certain important health plan activities that would preclude activities that improve care quality and also help contain treatment costs.

Second, Illinois should advocate large group market MLR aggregation at a national level and at the legal entity level as the current proposal implies that insurers would produce state by state minimum loss ratios for each legal entity in each market segment -- including the large group market. The large group market is comprised of sophisticated purchasers and is working well for employers and employees. A state by state legal entity reporting requirement would hurt consumers through:

Reduced Choice of Coverage. If insurers are required to report large group market MLRs on a state by state and legal entity basis, it would produce distorted MLRs for large employers with HMO, Point of Service and Dual Choice products. Consequently, insurers may not be able to offer these important options. The chart below highlights how large group market MLRs could be distorted under the proposed state by state NAIC framework.

- *HMO Coverage*: Many states require insurers to maintain a separately licensed HMO that is a separate legal entity. As a result, the large employer in the chart below that purchases from one national insurer is technically provided HMO coverage by three different HMO legal entities -- one in each of the three states where its employees are located. The insurer offers the employer a mutualized premium across all three entities of $303 per month even though the actual employee claim levels vary by state. This employer account has an 88% MLR in aggregate but the state by state MLRs vary from 81% to 93%. As a result, a rebate would be owed in one of the states. A significant portion of large group business is in HMO, as employers cannot easily self fund this product. The end result would be an inability for many insurers to offer HMO coverage to large employers.
- *Point of Service*: This same issue arises with point of service (POS) products. Consumers receive a financial incentive to obtain services "in-network" where coverage is underwritten by an HMO entity but the out- of- network services are often underwritten by a separate, indemnity, legal entity. As a result, an insurer offering POS coverage in these three states experiences a similar MLR distortion to the HMO situation. Attempting to split the MLR by the portion that is indemnity vs. HMO would produce misleading MLRs and employers may no longer be able to provide this option. This is why it is critical to combine MLR experience for these dual contract products.
- *Dual Option*: The final scenario occurs where a large employer offers employees a choice between PPO and HMO coverage. Insurers price dual option products by blending the HMO and PPO premiums. It is priced as a single product to the employer. Any requirement to separately calculate these would distort the MLRs and preclude the continued viability of these choices.

HMO Legal Entity	Mbrs	Required Premium	Required PMPM	Expected Claims	Priced to MLR	Mutualized Rate	Expected MLR w/Mutualized	Payback
State A	2,500	775,000	$ 310.00	$ 272.80	88.0%	$ 303.33	89.9%	-
State B	2,500	800,000	$ 320.00	$ 281.60	88.0%	$ 303.33	92.8%	-
State C	2,500	700,000	$ 280.00	$ 246.40	88.0%	$ 303.33	81.2%	$26,385
TOTAL	**7,500**	**2,275,000**	**$ 303.33**	**$ 266.93**	**88.0%**	**$ 303.33**	**88.0%**	**$26,385**
					After Rebate		**89.2%**	

Decreased Competition in the Large Group Market. Even in the large group market, insurers have relatively small enrollment in certain states. This is often the situation for states with small population levels. If insurers are required to report large employer Medical Loss Ratios on a state by state basis, it could disadvantage these small population states. The smaller the state, the more variability one might expect in the actual results. Credibility may dampen the volatility but doesn't eliminate it. If a carrier anticipates volatility would trigger rebates in small states performing better than expected – with no offsets for poor performing small states -- that carrier may decide to discontinue coverage in smaller states. In addition, this could deprive smaller states of beneficial rating practices. For instance, large employers at the low end of the size range (e.g., 150) may benefit today from rating practices that pool their experience with large employers in other states. State by state MLR reporting would threaten the ability of insurers to continue this rating practice. The end result would be fewer insurance choices for large employers in small population states.

Increased Administrative Costs. The large group market is a relatively efficient marketplace. However, it is characterized by multi-state and national employer accounts. Any requirement for insurers to disaggregate their expenses on a state by state basis would be administratively complex and expensive. State by state expense reporting is not required today and would require millions of dollars in systems changes. These additional costs would be passed onto large employers.

COST CONTAINMENT

Six months ago, when President Obama signed the Patient Protection Affordable Care Act (PPACA) into law, the country took a bold step toward reforming our health care system. Although the initial legislation does not adequately address affordability or cost containment, it will open up access to health care services for millions of Americans. To this end, as we implement reforms, we must consider that medical trend drives most premium increases and that this year trend increases were 10-12% alone. Cost containment will have to be addressed in order to stabilize premium increases. We must focus on what we can do to contain costs to assure healthcare adequacy, access and quality.

CONCULSION

While Aetna has an interest in many PPACA issues, we believe that Illinois exchange, its advocacy and implementation of MLR, and its position on cost containment are of utmost importance. Aetna appreciates the opportunity to input and I look forward to working with you.

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